HANFORD

FLEXIBLE BENEFITS PLAN

Effective January 1, 2023

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PROJECT HANFORD

FLEXIBLE BENEFITS PLAN

The Board of Trustees of the Hanford Employee Welfare Trust (the "Trust") hereby amends and restates the Hanford Flexible Benefits Plan as previously established under various names (the "Plan"), effective January 1, 2023, to update its provisions. The Plan is administered under the Hanford Employee Welfare Trust (the "Trust"). The Plan was initially effective January 1, 1993.

ARTICLE 1.

PURPOSE AND LEGAL EFFECT

1.1 Cafeteria Plan. This Plan is a cafeteria plan intended to qualify under Section 125 of the Code and regulations issued pursuant thereto, and shall be interpreted to accomplish that objective.

1.2 Nondiscriminatory. The Plan will be "nondiscriminatory" as that term is used in Code Section 125 and any subsequently issued regulations thereunder. The Employers (as defined below) reserve the right to take whatever steps are necessary to maintain the Plan as nondiscriminatory and to ensure continued qualification, including the right to adjust the amount of nontaxable benefits elected by Employees (as defined below). Any such reduction of nontaxable benefits shall be accomplished by reducing proportionately the nontaxable benefits elected by highly-compensated and/or key Employees.

1.3 Exclusive Benefits. This Plan shall be maintained for the exclusive benefit of Employees, their spouses and/or dependents, and is intended to provide them with a choice of certain nontaxable benefits or cash.

1.4 Separate Plans. This Plan document shall evidence separate flexible benefits plans for each of the Eligible Employers, which shall be separately administered.

ARTICLE 2.

DEFINITIONS

2.1 Administrator or Plan Administrator means the Board of Trustees of the Trust.

2.2 Adoption Agreements means the adoption agreements between each Employer and the Trust under which the Employer agrees to be bound by the terms of the Trust Agreement.

2.3 Board or Board of Trustees means the Board of Trustees appointed pursuant to the Trust Agreement. The appointment, removal, rights, duties, and powers of the Board of Trustees shall be as set forth in the Trust Agreement, in addition to those set forth in this Plan.

2.4 Change in Status. The following events are "Changes in Status" for the purposes of Section 8.2:

a. legal marital status change, including marriage, death of spouse, divorce, legal separation, or annulment;

b. change in number of Dependents, including through birth, adoption, placement for adoption, or death of a Dependent;

c. termination or commencement of employment by the Participant, spouse or Dependent;

d. a reduction or increase in hours of employment by the Participant, spouse or Dependent, including a switch between part-time and full-time, a strike or lockout, or commencement or return from unpaid leave of absence;

e. a Dependent's satisfying or ceasing to satisfy the eligibility requirements for coverage due to the attainment of age, student status, or any similar circumstance as provided

in the health plan under which the Participant receives coverage (including, a child of an Employee who becomes newly eligible for coverage as a result the Employers' permitting children under age 26 to participate in the medical plans in the Trust, effective January 1, 2011; a Participant may elect to enroll such newly eligible Dependent in such coverage as permitted by Treasury Regulations);

f. a change in the place of residence or work of the Participant, spouse, or Dependent; and

g. for purposes of the Dependent Care Assistance Plan, a change in the Participant's Dependent Care Service Provider or a significant increase or decrease in Dependent Care Expenses, if the Dependent Care Service Provider that imposes the cost change is not related to the Participant.

2.5 Change of Election Event means an event described in Section 8.2 which entitles a Participant to revoke an election and make a new election of his or her benefits under this Plan.

2.6 COBRA means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

2.7 Code means the Internal Revenue Code of 1986, as amended.

2.8 Dependent, for purposes of the Dependent Care Assistance Plan, means any individual who is (a) a dependent of the Participant as defined in Code Section 152(a)(1) who is under the age of 13, or (b) a dependent as defined in Code Section 152 (without reference to subsections (b)(1), (b)(2) and (d)(1)(B) or spouse of the Participant who is (a) physically or mentally incapable of caring for himself or herself and (b) has the same principal place of abode as the taxpayer for more than half the year; provided, however, that in the case of a divorced Employee, Dependent shall be as defined in Code Section 21(e)(5) (e.g. dependent of the parent

with custody). For purposes of the Premium Payment Plan and the Health Care Reimbursement Plan, Dependent shall mean any individuals who qualify as dependents under Code Section 152 (as modified by Code Section 105(b)). Dependent for purposes of the Health Care Reimbursement Plan shall also include an Employee's child who has not attained age 27 as of the end of the calendar year.

2.9 Dependent Care Assistance Plan means the Dependent Care Assistance Plan established pursuant to Section 6.1.

2.10 Dependent Care Expenses means expenses incurred by a Participant which (a) are incurred for the care of a Dependent of the Participant or for related household services that include the care of the Dependent, (b) are paid or payable to a Dependent Care Service Provider, and (c) are incurred to enable the Participant to be gainfully employed for any period during which the Participant has one or more Dependents. "Dependent Care Expenses" shall not include (i) amounts paid for services at an overnight camp, or (ii) expenses incurred for services outside the Participant's household for the care of a Dependent unless such Dependent is described in Section 2.10(a) or regularly spends at least eight (8) hours each day in the Participant's household.

2.11 Dependent Care Service Provider means a person who provides care or other services described in Section 2.10, but shall not include (a) a dependent care center (as defined in Code Section 21(b)(2)(D)), unless the requirements of Code Section 21(b)(2)(C) are satisfied, or a related individual described in Code Section 129(c).

2.12 Dependent Care Spending Account means the Dependent Care Spending Account established pursuant to Section 6.2.

2.13 Effective Date of this amended and restated Plan is January 1, 2023. The Plan was originally effective January 1, 1993.

2.14 Election Form means an Employee election form provided by and filed with the Plan Administrator.

2.15 Eligible Employee means an Employee who is eligible to become a Participant. Refer to "Eligible Employers" (Schedule A). The following may be eligible: (a) regular, Hanford Atomic Metal Trades Council ("HAMTC") represented, (b) regular, Hanford Guards Union ("HGU") represented, and (c) salaried, regular full-time or part-time unrepresented Employees working a minimum of twenty (20) hours per week. Temporary and hourly paid Employees shall not be eligible. Subject to applicable insurance laws and regulations and the rules of the Trust, each Employer shall specify to the Trustees in writing those Employees, and their Dependents satisfying the foregoing requirements who shall be eligible to participate in the Plan. Individuals who are leased by the Employer that is the recipient of that individual's services are not eligible.

2.16 Eligible Employer means those Employers who are listed on Schedule A hereto.

2.17 Employee means any person who is employed by an Employer. Employees do not include individuals who are characterized by their Employer as an independent contractor, regardless of how that individual is classified under applicable state or federal law.

2.18 Employer means any Eligible Employer that has executed an Adoption Agreement, which may be effective retroactively, including the Initial Employer.

2.19 Enrollment Period means all or part of October and/or November, as more specifically designated by the Administrator.

2.20 ERISA means the Employee Retirement Income Security Act of 1974, as amended.

2.21 **FMLA** means the Family and Medical Leave Act of 1993, as amended.

2.22 **HDHP** means a health plan intended to qualify as a high deductible health plan under Code Section 223(e)(2).

2.23 **Health Care Reimbursement Plan** means the Health Care Reimbursement Plan established pursuant to Section 5.1.

2.24 **Health Care Spending Account** means the Health Care Spending Account established pursuant to Section 5.2.

2.25 **Health Insurance, Plan or Coverage** includes without limitation health, medical, dental, or vision insurance, plan or coverage.

2.26 **HIPAA** means the Health Insurance Portability and Accountability Act of 1996, as amended.

2.27 **HSA** means the health savings account described in Article 7.

2.28 **Initial Employer** and initial sponsor of this Plan means Fluor Hanford, Inc. acting in its capacity under the Project Hanford Management Contract ("PHMC").

2.29 **Limited Health Care Reimbursement Plan** means the Limited Health Care Reimbursement Plan established pursuant to Section 5.1.

2.30 **Limited Health Care Spending Account** means the Limited Health Care Spending Account established pursuant to Section 5.2 and Treasury Regulations Section 1.125-5 that reimburses only permitted coverage benefits (as defined in Code Section 223(c)(2)(C)) such as vision care, dental care or preventive care.

2.31 **Medical Expenses** means amounts paid for medical care as defined in Code Sections 106(f) and 213(d) for the Participant, his or her spouse and/or Dependents.

2.32 Participant means an Employee who has been enrolled as a participant in this Plan under Article 3.

2.33 Plan means this document, rules published by the Plan Administrator, the Trust Agreement, the Adoption Agreements, and any notice to Employees required by the Code.

2.34 Plan Year means the 12-month period from January 1 to December 31, or effective date of enrollment through December 31 of the same calendar year.

2.35 Premium Payment Plan means the Premium Payment Plan established pursuant to Article 4.

2.36 Qualified Benefits means the employee welfare benefits specified by the Trustees from time to time under the Trust Agreement as being included as Qualified Benefits under this Plan. Initially, the Qualified Benefits shall be the medical plans and the dental plans maintained by the Trust. Effective beginning January 1, 2014, a "qualified health plan" offered through an "Exchange" as established under the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010 shall not be a Qualified Benefit under this Plan; provided, that the foregoing shall not apply to an Employee if the Employer is a qualified employer under such law offering the Employee the opportunity to enroll through such an Exchange in a qualified health plan in a group market.

2.37 Salary or Wages means salary or wages for personal service excluding overtime (except in the case of platoon firefighters during regular platoon scheduled work), shift differential, severance pay, or any other extraordinary pay, and excluding contributions to any retirement plan or on account of medical disability and life insurance.

2.38 Trust means the Hanford Employee Welfare Trust established under the Trust Agreement.

2.39 Trust Agreement means the Hanford Employee Welfare Trust Agreement entered into by and among Fluor Hanford, Inc. as the Initial Employer and the Initial Trustees dated January 1, 2000.

2.40 USERRA means the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended.

ARTICLE 3.

PARTICIPATION; TRANSFERS

3.1 General. All Eligible Employees will become Participants during an annual Enrollment Period or upon initially becoming eligible. If an Eligible Employee does not enroll within 31 days of first becoming eligible, the Employee must wait until the next Enrollment Period to enroll, except on the occurrence of an applicable Change of Election Event.

3.2 Termination of Participation. A Participant shall no longer participate in this Plan upon the occurrence of any of the following events:

a. his termination of employment, subject to the provisions of Section 3.3;

b. his death subject to provisions of Section 3.4;

c. the termination of this Plan, subject to the provisions of Section 10.1; or

d. transfer to an ineligible class, see "Eligible Employers" (Schedule A).

3.3 Termination of Employment - Transfer to Ineligible Class. If a Participant's employment with his Employer is terminated for any reason other than death or if the Participant transfers to an ineligible class of Employees, then subject to the provisions of Section 3.4, his participation in the Plan shall be governed in accordance with the following:

a. With regard to benefits that are insured, the Participant's participation in the Plan shall cease, but coverage under any insurance contract for which premiums have already been paid shall continue for the period for which premiums are paid.

b. With regard to the Dependent Care Assistance Plan, the Participant's participation in the Plan shall cease and no further employee contribution shall be made. However, such Participant may submit claims for expenses incurred through the date on which the Participant terminates employment, as provided in Section 6.5. Any amount still credited to the Participant's Dependent Care Assistance account after the applicable period for filing claims expires shall be forfeited.

c. With regard to the Health Care Reimbursement Plan or the Limited Health Care Reimbursement Plan, the Participant's participation shall cease unless extended under COBRA in accordance with Section 10.9(f). No further contributions shall be made. However, such Participant may submit claims for Medical Expenses incurred through the date on which the Participant terminates employment, as provided in Section 5.4. Any amount still credited to the Participant's Health Care Reimbursement Plan account or Limited Health Care Reimbursement Plan account after the expiration of the period for filing claims expires shall be forfeited.

d. With regard to an HSA, the Participant's participation in the Plan ceases and no further contributions shall be made.

e. Death. If a Participant dies, participation in the Plan shall cease. However, such Participant's beneficiaries, or the representative of the Participant's estate may submit claims incurred prior to death for the applicable period for filing claims pursuant to this Plan document. A Participant may designate a specific beneficiary for this purpose. If no such

beneficiary is specified, the Administrator may designate the Participant's spouse, one of his Dependents or a representative of his estate.

3.4 Transfers Between Employers. From time to time, Eligible Employees of one Employer may cease to work for such Employer and become employed by another Employer as a result of an official transfer of work scope, mandated by the Department of Energy, or related to a change in work relating to the Labor Assets Management Program. This Section 3.4 shall not apply to changes in employment between participating Employers by salaried unrepresented Employees.

All of the Employers desire that the Eligible Employees of one Employer who become employed by another Employer continue to receive the benefits afforded them under their medical and dental insurance, Health Care Spending Accounts, Limited Health Care Spending Accounts, Dependent Care Spending Accounts, and HSAs, and continue to pay premiums pre-tax as if their employment with the former Employer had not ended. Therefore, for purposes of this Plan, a Participant who transfers from the employ of one Employer to another Employer shall not be deemed to have terminated his or her employment or separated from service as a result. Without limiting the foregoing, upon such transfer the Participant's Election Form (and elections made therein) shall continue in full force and effect. In addition, any payroll deduction authorizations made by such Participants shall continue in full force and effect and apply to deductions made by the Employer to which the Participant transferred. Health Care, Limited Health Care and Dependent Care Spending Accounts established by a Participant with one Employer shall continue in full force and effect upon transfer to the other Employer, and the amounts in such Accounts shall not be forfeited.

ARTICLE 4.

PREMIUM PAYMENT PLAN

The Premium Payment Plan is hereby established. Upon becoming eligible, a Participant may elect in writing on an Election Form (a) to reduce his or her Salary or Wages each pay day by an amount equal to the Participant's, spouse's and dependents' premiums otherwise payable by the Participant for the Qualified Benefits, and (b) to have the Employer apply the amount of the salary reduction to pay such premiums on a pre-tax basis. Participants who at any time have signed a payroll deduction authorization to pay such premiums shall be deemed to have authorized a reduction from Salary or Wages to pay such premiums on a pre-tax basis. If a Participant does not elect upon initial enrollment to pay such premiums on a salary reduction pre-tax basis, he or she may later elect to do so by executing an Election Form during the Enrollment Period, effective as of the following January. Nothing in this provision precludes an Employee from paying for any Qualified Benefits on an after-tax basis.

In accordance with Code Sections 105(b) and 106, notwithstanding the Plan's definition of Dependent, the Plan shall exclude from an Employee's gross income (i) amounts received by an Employee for medical care (as defined in Code Section 213) of, and (ii) employer-provided coverage under an accident or health plan for, an Employee's child (within the meaning of Code Section 152(f)(1)) who has not attained age 27 as of the end of the calendar year.

ARTICLE 5.

HEALTH CARE REIMBURSEMENT PLAN

5.1 Purpose. The Health Care Reimbursement Plan is hereby established. It is intended to qualify under Code Sections 105 and 106 and shall be interpreted in a manner consistent with the requirements of such Sections. The purpose of the Health Care

Reimbursement Plan is to reimburse Participants' uninsured Medical Expenses. Reference to a Health Care Reimbursement Account in this Article 5 shall be interpreted to include a Limited Health Care Reimbursement Account unless the context requires otherwise.

5.2 Establishing an Account; Payment of Expenses. The Plan Administrator will establish and maintain a Health Care Spending Account for each Participant hereunder. From amounts credited to a Participant's Health Care Spending Account during a Plan Year, there shall be paid from time to time reimbursement of Medical Expenses incurred by the Participant, Participant's spouse and/or Dependents during the Plan Year.

5.3 Participation. Upon becoming eligible, a Participant may elect in writing on an Election Form to reduce the Participant's Salary or Wages monthly and to have the amount of the reduction contributed to a Health Care Spending Account on such Participant's behalf. The Election Form shall be filed with the Plan Administrator prior to the date the Participant is enrolled in the Plan.

The minimum amount of such election per Plan Year is $120 and such election may not reduce the Participant's Salary or Wages by more than the maximum permitted under Code Section 125(i) ($3,050 for 2023) during a Plan Year (as such amount may be increased in future Plan Years for cost-of-living adjustments). If a Participant elects not to establish a Health Care Spending Account, the Participant may later elect to establish such an Account during the Enrollment Period, effective as of the following January.

A Participant who is enrolled in an HSA may participate only in a Limited Health Care Spending Account, not a regular Health Care Spending Account.

The maximum amount which a Participant may receive for any Plan Year for reimbursement of Medical Expenses shall be the amount credited to the Participant's Health

Care Spending Account during the Plan Year under this Section 5.3, plus any Carryover Amount, as determined under Section 5.5. The Plan Administrator shall credit to a Participant's Health Care Spending Account as of the first day of the Plan Year the maximum dollar amount for which the Participant shall have subscribed for such Plan Year (not to exceed the maximum permitted under Code Section 125(i) ($3,050 for 2023), (as such amount may be increased in future Plan Years for cost-of-living adjustments). Such amount shall be available to a Participant at all times during the period of coverage (reduced as of any time for prior reimbursements for the same period of coverage), and a Participant shall be entitled at least monthly to seek reimbursement for Medical Expenses up to such amount.

5.4 Claim for Reimbursement. In order to obtain reimbursement for Medical Expenses, a Participant shall submit an application in writing to the Plan Administrator in such form and in such detail as the Plan Administrator may prescribe with the following information:

a. The amount, date and nature of the expense.

b. The name of the person, organization or entity to which the expense was or is to be paid.

c. Such other information as the Plan Administrator may from time to time require.

Such application shall be accompanied by bills, invoices, receipts, cancelled checks or other statements showing the amount of such expenses. The Participant must provide a written statement from an independent third party verifying the Medical Expenses incurred and the amount of such expenses, and must verify in writing that the expenses have not been reimbursed and are not reimbursable under any other health plan.

A Participant has until March 31 following the end of the Plan Year to obtain reimbursement for Medical Expenses incurred during the preceding Plan Year. Any amounts still credited to the Participant's Health Care Spending Account after April 1 shall be forfeited in accordance with Section 5.5.

The Trust shall reimburse the Participant from the Participant's Health Care Spending Account for Medical Expenses incurred during the Plan Year for which the Participant submits documentation in accordance with this Section 5.4. Reimbursements will be made from the amounts the Participant has elected to contribute to the Health Care Spending Account for the Plan Year and then, after these amounts for the Plan Year are exhausted, from the Carryover Amount.

Except for Medical Expenses for orthodontia, for which reimbursement of prepaid amounts from the Participant's Health Care Spending Account is permitted, Medical Expenses will be treated as having been incurred when the care is provided, and not when the Participant is formally billed, charged for, or pays for the expenses. Expenses that were incurred before the Effective Date or before the date the Participant was enrolled in the Plan will not be reimbursed. The Plan Administrator may, at its option, pay any Medical Expense directly to the medical care provider in lieu of reimbursing the Participant.

Pursuant to the Heroes Earnings Assistance and Relief Tax Act of 2008 ("HEART Act of 2008"), Participants who are military reservists and who are called into active duty for 180 or more days or for an indefinite period may receive a distribution of all or a portion of the unused funds in their Health Care Spending Account. For purposes of this paragraph, "unused funds" refers to the total amount the Participant has elected to contribute to the Health Care Spending Account for the Plan Year, plus the Participant's Carryover Amounts, if any, minus the claims

qualifying for reimbursement from the Health Care Spending Account for Medical Expenses incurred by the Participant and his or her Dependents from the beginning of the Plan Year up to and including the date the Participant requests the distribution. Distributions made under the HEART Act of 2008 must be made during the period beginning on the date the Participant is ordered or called into active duty and ending on the last day reimbursement from the Health Care Spending Account would otherwise be made for the Plan Year.

5.5 Forfeiture and Carryover of Health Care Spending Account Balances. After the processing of all claims for a Participant for pursuant to Section 5.4 for a Plan Year, amounts remaining in the Participant's Health Care Spending Account which are not applied to pay Medical Expenses for the Plan Year will be forfeited; provided, effective January 1, 2014, amounts remaining in a Participant's Health Care Spending Account (or, if less, $500 of such balance), which are not applied to pay Medical Expenses for the Plan Year will be carried over (the "Carryover Amount") and will be available to pay the Participant's Medical Expenses for a subsequent Plan Year. The Plan Administrator shall credit Participant's Carryover Amount, if any, to the Participant's Health Care Spending Account as soon as administratively practicable after the calculation of the Carryover Amount.

5.6 Termination of Participation. Upon a Participant's cessation of participation in the Plan, Participant may file claims until March 31 following the end of the Plan Year in which coverage terminates, but only for claims incurred through the date on which the Participant terminates employment, unless extended under COBRA in accordance with Section 10.9(f).

ARTICLE 6.

DEPENDENT CARE ASSISTANCE PLAN

6.1 Purpose. The Dependent Care Assistance Plan is hereby established. It is intended to qualify under Code Section 129, and shall be interpreted in a manner consistent with the requirements of such Section. The purpose of the Dependent Care Assistance Plan is to reimburse Participants' Dependent Care Expenses.

6.2 Establishing an Account; Payment of Expenses. The Plan Administrator will establish and maintain a Dependent Care Spending Account for each Participant hereunder. From amounts credited to a Participant's Dependent Care Spending Account during the Plan Year, there shall be paid from time to time reimbursement of Dependent Care Expenses incurred by the Participant during the Plan Year.

6.3 Participation. Upon becoming eligible, a Participant may elect in writing on an Election Form to reduce his or her Salary or Wages monthly and to have the amount of the reduction contributed to a Dependent Care Spending Account on such Participant's behalf. The Election Form shall be filed with the Plan Administrator prior to the date the Participant is enrolled in the Plan. The minimum amount of such election per Plan Year is $120, and such election may not reduce the Participant's Salary or Wages by more than $5,000 per Plan Year ($2,500 in the case of married individuals filing separate returns). If a Participant elects not to establish a Dependent Care Spending Account upon initially becoming eligible, he or she may later elect to establish such an Account during an Enrollment Period, effective as of the following January.

The maximum amount which a Participant may receive for any Plan Year for reimbursement of Dependent Care Expenses shall be the lesser of (a) the amount credited to his

or her Dependent Care Spending Account during the Plan Year, (b) the lesser of the Participant's earned income, or the earned income of the Participant's spouse as defined in Code Section 32(c)(2), or (c) $5,000 (or $2,500 in the case of married individuals filing separate returns).

6.4 Claims for Reimbursement. In order to obtain reimbursement for Dependent Care Expenses, a Participant shall submit an application in writing to the Plan Administrator, in such form as the Plan Administrator may prescribe, setting forth:

a. the amount, date and nature of the expense with respect to which payment is requested;

b. the name of the person, organization or entity to which the expense was or is to be paid, and taxpayer identification number (Social Security number, if an individual); and

c. such other information as the Plan Administrator may from time to time require.

Such application shall be accompanied by bills, invoices, receipts, canceled checks or other statements showing the amounts of such expenses. The Participant must provide a written statement from an independent third party verifying the Dependent Care Expenses incurred and the amount of such expenses, and must verify in writing that the expenses have not been reimbursed under any other dependent care assistance plan.

A Participant has until March 31 following the end of the Plan Year to obtain reimbursement for Dependent Care Expenses incurred during the preceding Plan Year. Any amounts still credited to the Participant's Dependent Care Spending Account after April 1 shall be forfeited.

The Trust shall reimburse the Participant from the Participant's Dependent Care Spending Account for Dependent Care Expenses incurred during the Plan Year for which the Participant submits documentation in accordance with this Section 6.4. Dependent Care Expenses will be treated as having been incurred when the care is provided, and not when the Participant is formally billed, charged for, or pays for the Dependent Care. Expenses that were incurred before the Effective Date or before the date the Participant was enrolled will not be reimbursed. The Plan Administrator may, at its option, pay any Dependent Care Expense directly to the Dependent Care Service Provider in lieu of reimbursing the Participant.

6.5 Termination of Participation. Upon termination of Participation, the Participant shall be entitled to reimbursement of Dependent Care Expenses from his or her Dependent Care Spending Account for expenses incurred through the date of termination to the extent of amounts remaining in the Participant's Dependent Care Account at the time the Participant terminates employment.

No reimbursement or payment under this Section 6.5 of Dependent Care Expenses incurred during a Plan Year shall at any time exceed the balance of the Participant's Dependent Care Spending Account for the Plan Year at the time of the reimbursement or payment. The amount of any Dependent Care Expenses not reimbursed or paid as a result of the preceding sentence shall be carried over to subsequent month(s) during the same Plan Year and reimbursed or paid only if and when the balance in such Account permits such reimbursement or payment.

6.6 Report to Participants on or Before January 31 of Each Year. On or before January 31 of each year, the Plan Administrator shall furnish to each Participant who has received reimbursement for Dependent Care Expenses during the prior calendar year a written

statement showing the Dependent Care Expenses paid during such year with respect to the Participant.

ARTICLE 7.

HEALTH SAVINGS ACCOUNT

7.1 HSA Benefits.

a. Effective for the Plan Year beginning on January 1, 2023, and thereafter to the extent HSA benefits are available under the Plan, the Employer shall open an HSA for each Participant who elects to participate in a HDHP and who is eligible for an HSA. The HSA permits Participants to elect in writing on an Election Form to reduce the Participant's Salary or Wages and to have the amount of the reduction contributed on a pre-tax basis to the Participant's HSA established and maintained outside the Plan by a single trustee/custodian to which the Plan Administrator can forward contributions to be deposited. Such election can be increased, decreased or revoked prospectively in accordance with procedures established by the Plan Administrator, effective no later than the first day of the next calendar month following the date that the election change was filed and using Salary or Wages that is currently unavailable to the Employee. HSA contributions may not be made under this Plan to any provider other than the single trustee/custodian designated by the Plan Administrator.

b. A Participant enrolled in an HSA may not participate in a regular Health Care Spending Account.

c. A Participant enrolled in a health reimbursement arrangement (other than the Limited Health Care Spending Account), coverage that is not a HDHP, or any other type of coverage that prevents HSA eligibility under applicable law may not participate in an HSA.

d. This Article 7 shall only be applicable if an HSA is available under the Plan.

7.2 Contributions For Cost of Coverage for HSA; Maximum Limits.

a. The Employer may make contributions to the HSA on behalf of Participants in an amount and in a manner to be determined by the Plan Administrator, in its sole discretion. Any such Employer contributions shall be treated as being made through a cafeteria plan for purposes of the applicable comparability regulations. In the event of a mistaken contribution by the Employer, the Employer shall have the right to recoup such contribution by reducing or offsetting future contributions until the Employer has recovered the amount(s) mistakenly contributed.

b. A Participant may elect an annual contribution amount to an HSA for a Plan Year.

c. In no event shall the amount elected by a Participant plus any contributions made by the Employer exceed the statutory maximum amount for HSA contributions applicable to the Participant's HDHP coverage option (i.e., $3,850 for single coverage and $7,750 for family coverage for 2023, as indexed for inflation) for the calendar year in which the contribution is made.

d. An additional catch-up contribution of $1,000 may be made for Participants who are age 55 or older.

e. The maximum annual contribution may be pro-rated for the number of months in which the Participant is covered by a HDHP.

7.3 Recording Contributions for HSA. The HSA trustee/custodian, not the Employer or Plan Administrator, will establish and maintain an HSA. The HSA trustee/custodian

will be chosen by the Employer or the Plan Administrator. The Plan Administrator may, however, limit the number of HSA providers to whom it will forward contributions that the Participant makes via pre-tax salary reduction contributions, without endorsing any particular HSA provider. The Plan Administrator will maintain records to keep track of HSA contributions a Participant makes via pre-tax salary reduction contributions, but it will not create a separate fund or otherwise segregate assets for this purpose. The Employer has no authority or control over the funds deposited in an HSA.

7.4 Trust/Custodial Agreement; HSA Not Intended to Be A Benefit Plan.

a. HSA benefits under this Plan consist solely of the ability to make contributions to an HSA on a pre-tax salary reduction basis. Terms and conditions of coverage and benefits (e.g., eligible medical expenses, claims procedures, etc.) will be provided by and are set forth in the medical plan. The terms and conditions of each Participant's HSA trust or custodial account are described in the HSA trust or custodial agreement provided by the applicable trustee/custodian to each selecting Participant and are not a part of this Plan.

b. An HSA is not an employer-sponsored employee benefit plan. It is a savings account that is established and maintained by an HSA trustee/custodian outside this Plan to be used primarily for reimbursement of "qualified eligible medical expenses" as set forth in Code Section 223(d)(2). The Employer has no authority or control over the funds deposited in an HSA. Even though this Plan may allow pre-tax salary reduction contributions and Employer contributions to an HSA, the HSA is not intended to be a benefit plan sponsored or maintained by the Employer and is not subject to ERISA.

ARTICLE 8.

ELECTION OF BENEFITS

8.1 Initial Election. A Participant's election of nontaxable benefits or cash shall be in writing and filed with the Plan Administrator during the Enrollment Period and prior to the effective date of the election. The Participant shall execute such payroll reduction authorization as the Plan Administrator shall require. When a new benefit is first offered under the Plan, the Participant may file a written election with respect to that benefit within an initial Enrollment Period established by the Plan Administrator. Once an election is made under Section 8.2, the Participant may change that election only during a regular Enrollment Period, except on the occurrence of an applicable Change of Election Event.

8.2 Changes of Election. A Participant's election to apply the salary reduction to the payment of premiums for Qualified Benefits, or to the payment of contributions to the Health Care Spending Account, the Limited Health Care Spending Account or the Dependent Care Spending Account, will be irrevocable for the balance of the Plan Year, except in certain situations described in this Section 8.2. This Section 8.2 shall not apply to HSA elections, which may be made, or prospectively revoked or changed at any time during the Plan Year by the Participant, but only using salary that is not yet currently available. Any of the following elections and revocations shall be made pursuant to procedures adopted by the Plan Administrator and shall be effective no sooner than the first of the month coinciding with or immediately following the date the Participant files a new election with the Plan Administrator. An election change may be funded through pre-tax salary reduction only on a prospective basis, except for the retroactive enrollment right under Code Section 9801(f), which applies in the case of an election made within 60 days of a birth, adoption, or placement for adoption. A Participant

otherwise entitled to make a new election under this Section 8.2 must do so within 31 days of the event. The circumstances under which a Participant may make a mid-year change of election vary with the type of plan at issue, as follows:

a. Change in Status. A Participant may change an election during the Plan Year if a Change in Status as defined in Section 2.4 has occurred and the requested election change is consistent with the Change in Status. An election change will be consistent with the Change in Status where the change affects Health Coverage only if the change is on account of and corresponds with a Change in Status that affects eligibility for coverage, including a change that results in an increase or decrease in the number of an employee's family members or dependents. An election change also satisfies the requirement if it is on account of and corresponds with a Change in Status that affects Dependent Care Expenses under Article 6.

b. COBRA or Continuation Coverage. If the Participant, or Participant's spouse or Dependent becomes eligible for continuation coverage, the Participant may elect to increase salary reduction contributions hereunder in order to pay for the continuation coverage.

c. Health Insurance Portability and Accountability Act of 1996 ("HIPAA") Enrollment Rights. A Participant may revoke an election with respect to Health Coverage or coverage under the Health Care Reimbursement Plan or the Limited Health Care Reimbursement Plan and make a new election that corresponds with the Participant's special enrollment rights granted the Participant under Code Section 9801(f), whether or not the change in election is otherwise permitted under this Plan.

d. FMLA Leave. A Participant who takes FMLA leave may revoke an existing election of Health Coverage or coverage under the Health Care Reimbursement Plan or

the Limited Health Care Reimbursement Plan and make such other election for the remaining portion of the Plan Year as may be provided for under the FMLA and applicable regulations.

e. Judgments, Decrees and Orders. If a judgment, decree or order (an "Order") resulting from a divorce, legal separation, annulment, or change in legal custody requires accident or health coverage for a Participant's child or for a foster child who is a Dependent of the Participant, a Participant may change Participant's election of Health Coverage or coverage under the Health Care Reimbursement Plan or the Limited Health Care Reimbursement Plan to: (A) provide coverage for the child (provided that the Order requires the Participant to provide coverage for the child under the Participant's Plan), or (B) cancel coverage for the child if the Order requires the spouse, former spouse, or other individual to provide coverage for the child, and that coverage is, in fact, provided.

f. Medicare and Medicaid. If a Participant, spouse or Dependent who is enrolled in Health Coverage or who receives benefits under the Health Care Reimbursement Plan or the Limited Health Care Reimbursement Plan becomes entitled to Medicare or Medicaid (other than coverage consisting solely of benefits under Section 1928 of the Social Security Act providing for pediatric vaccines), the Participant may make a prospective election change under this Plan to cancel or reduce coverage for that Participant, spouse or Dependent under the Health Coverage, the Health Care Reimbursement Plan or the Limited Health Care Reimbursement Plan. In addition, if a Participant, spouse, or Dependent who has been entitled to Medicare or Medicaid loses eligibility for such coverage, the Participant may make a prospective election to commence or increase coverage for that Participant, spouse, or Dependent under the Health Coverage, the Health Care Reimbursement Plan or the Limited Health Care Reimbursement Plan.

g. Cost Changes with Automatic Increases/Decreases. A change in the cost of Health Coverage during the course of a Plan Year that is not deemed to be significant will automatically trigger a prospective increase or decrease in affected Participants' elections to have amounts deducted from their Salary or Wages. The Administrator (in its sole discretion) will decide in accordance with prevailing IRS guidance, whether increases in costs are significant or not, based on all the surrounding facts and circumstances. This subsection (g) does not permit a change of an election under the Health Care Reimbursement Plan or the Limited Health Care Reimbursement Plan.

h. Significant Coverage Changes. A Participant may prospectively change a premium payment election for Health Coverage in the event of a significant cost change. The Administrator (in its sole discretion) will decide, in accordance with prevailing IRS guidance, whether a cost increase is significant and whether substituted coverage constitutes "similar coverage," based on all the surrounding facts and circumstances.

If the amount charged to a Participant by a dependent care provider significantly changes during the Plan Year, the Participant may make a new election on a prospective basis under the Dependent Care Assistance Plan to reflect the change in the dependent care provider's pay. Such an election change is permitted only if the cost change is imposed by a dependent care provider who is not a relative of the Employee, as described in Code Section 152(a)(1)-(8). This subsection (h) does not permit a change of an election under the Health Care Reimbursement Plan or the Limited Health Care Reimbursement Plan.

i. Significant Coverage Curtailment. If Health Coverage is significantly curtailed, an affected Participant may revoke his or her election under this Plan and, in lieu thereof, elect to receive on a prospective basis coverage under another benefit package option

providing similar coverage. Health Coverage is deemed "significantly curtailed" only if there is an overall reduction in coverage so as to constitute reduced coverage to Participants generally. The Plan Administrator (in its sole discretion) will decide in accordance with prevailing IRS guidance, whether a curtailment is "significant" and whether substituted coverage is "similar," based upon all the surrounding facts and circumstances. If a Participant has a significant curtailment of coverage under the Dependent Care Assistance Plan, then that Participant may make a new election on a prospective basis under the Dependent Care Assistance Plan. This subsection (i) does not permit a change of an election under the Health Care Reimbursement Plan or the Limited Health Care Reimbursement Plan.

j. Significant Coverage Change with Loss of Coverage. If Health Coverage is significantly curtailed to the extent that it constitutes a loss of coverage, then the affected Participant may revoke his or her election under this Plan and, in lieu thereof, elect to either receive on a prospective basis coverage under another benefit package option providing similar coverage or to drop coverage if no similar benefit package option is available. For purposes of this Plan, a "loss of coverage" means a complete loss of coverage under the benefit package option or other coverage option (including the elimination of a benefits package option, an HMO ceasing to be available in the area where the individual resides, or the individual losing all coverage under the option by reason of an overall lifetime or annual limitation). In addition, the Plan Administrator may, in its discretion, treat the following as a loss of coverage:

(1) A substantial decrease in the medical care providers available under the option (such as a major hospital ceasing to be a member of a preferred provider network or a substantial decrease in the physicians participating in a preferred provider network or an HMO);

(2) A reduction in the benefits of a specific type of medical condition or treatment with respect to which the Employee or the Employee's spouse or Dependent is currently in a course of treatment; or

(3) Any other similar fundamental loss of coverage.

This subsection (j) does not permit a change of an election under the Health Care Reimbursement Plan or the Limited Health Care Reimbursement Plan.

k. Addition or Improvement of a Benefit Package Option. If during a Plan Year a new benefit package option or other coverage option is added, or an existing benefit package option or other coverage option is significantly improved, an affected Participant (whether or not he or she has previously made an election under this Plan or previously elected the benefit package option) may elect to revoke a prior election under this Plan and, in lieu thereof, make an election on a prospective basis for coverage under the new or improved benefit package option. The Plan Administrator (in its sole discretion) will decide in accordance with prevailing IRS guidance whether a benefit package option or other coverage option is added or significantly improved based upon all the surrounding facts and circumstances. This subsection (k) does not permit a change of an election under the Health Care Reimbursement Plan or the Limited Health Care Reimbursement Plan.

l. Other Changes. Under this Plan, a Participant may make an election on a prospective basis on account of and corresponding with changes in a cafeteria plan of another employer or a group health plan sponsored by a governmental or educational institution as permitted under regulations prescribed by the Secretary of the Treasury.

m. Election Rights Upon Reemployment. Upon termination of employment and reemployment and becoming eligible hereunder, a Participant may make new elections

under this Plan, except that with respect to the Health Care Reimbursement Plan account or the Limited Health Care Reimbursement Plan account if coverage has not been maintained during the period of absence, a new period of coverage will begin upon the Participant's election to participate in the Health Care Reimbursement Plan or the Limited Health Care Reimbursement Plan, as applicable.

8.3 Maximum Contributions. The maximum amount of salary reduction contributions that will be made for any Participant during a Plan Year shall be the sum of maximum allowable contributions to the Health Care Reimbursement Plan or the Limited Health Care Reimbursement Plan, maximum allowable contributions to the Dependent Care Assistance Plan, maximum allowable HSA contributions, and maximum allowable contributions to the Premium Payment Plan. The maximum allowable contributions to the Health Care Reimbursement Plan or the Limited Health Care Reimbursement Plan is the maximum permitted under Code Section 125(i) ($3,050 for 2023) (as such amount may be increased in future Plan Years for cost-of-living adjustments). The maximum annual contribution to the Dependent Care Assistance Plan is $5,000. The maximum annual HSA contributions are $3,850 for single coverage and $7,750 for family coverage for 2023, as indexed for inflation. The maximum annual contribution to the Premium Payment Plan is the maximum annual premium for any group health plan offered in the annual enrollment materials for the Premium Payment Plan.

ARTICLE 9.

ADMINISTRATION

9.1 Plan Administrator. The administration of the Plan shall be under the supervision of the Plan Administrator, which is the Board of Trustees for the Trust. The rights, duties, powers, action and authority of the Board of Trustees shall be as set forth in the Trust

Agreement. The Plan Administrator is also the fiduciary of the Health Care Reimbursement, the Limited Health Care Reimbursement, Dependent Care Assistance, and Premium Payment Plans. It shall be a principal duty of the Plan Administrator to see that the Plan is carried out in accordance with its terms, and for the exclusive benefit of persons entitled to participate in the Plan without discrimination among them. The Plan Administrator will have the authority and sole, absolute and uncontrolled discretions to control and manage the operation and administration of the Plan in accordance with applicable laws and shall have all powers necessary to accomplish such purposes. For this purpose, the Plan Administrator's powers will include, but will not be limited to, the following authority, in addition to all other powers provided by this Plan:

a. To make and enforce such rules and regulations that it deems necessary or proper for the efficient administration of the Plan, including the establishment of any claims procedures that may be required by applicable provisions of law, which shall be uniformly and consistently applied to all Participants in the administration of the Plan;

b. To interpret the Plan, its interpretation thereof in good faith to be final and conclusive on all persons claiming benefits under the Plan;

c. To decide all questions concerning the Plan and the eligibility of any person to participate in the Plan;

d. To appoint such agents, counsel, accountants, consultants and other persons as may be required to assist in administering the Plan; and

e. To allocate and delegate its responsibilities under the Plan and to designate other persons to carry out any of its responsibilities under the Plan, any such

allocation, delegation or designation to be by written instrument and in accordance with applicable requirements of law.

9.2 Reliance on Participant. The Plan Administrator may rely upon the direction, information or election of a Participant as being proper under the Plan and shall not be responsible for any act or failure to act because of a direction or lack of direction by a Participant.

9.3 Examination of Records. The Plan Administrator will make available to each Participant such of its records under the Plan as pertain to such Participant, for examination at reasonable times during normal business hours.

9.4 Reliance on Tables, etc. In administering the Plan, the Plan Administrator will be entitled, to the extent permitted by law, to rely conclusively on all tables, valuations, certificates, opinions and reports which are furnished by accountants, counsel or other experts employed or engaged by the Plan Administrator.

9.5 Payment of Expenses. Any reasonable administrative expenses shall be paid by the Employers or may be charged against Participant's accounts, as determined by the Trustees in their sole discretion.

9.6 Insurance Control Clause. In the event of a conflict between the terms of this Plan and the terms of an insurance contract of an independent third party insurer whose product is then being used in conjunction with this Plan, the terms of the Insurance Contract shall control as to those Participants receiving coverage under such Insurance Contract. For this purpose, the Insurance Contract shall control in defining the person's eligibility for such insurance, the dates of theirs eligibility, the conditions which must be satisfied to become insured, if any, the benefits Participants are entitled to and the circumstances under which the insurance terminates.

ARTICLE 10.

MISCELLANEOUS

10.1 Amendment and Termination of Plan. The Trustees shall have the right to amend, modify and terminate any or all of the provisions of this Plan by action of the Board of Trustees, provided, however, that no such amendment, modification or termination shall be in violation of the requirements of Section 6.01 of the Trust Agreement or ERISA. Notice of any amendment or modification shall be promptly forwarded to the Board of Trustees, each Employer and any applicable insurer, and on request a copy shall be furnished to any such person. In the event of termination of the Plan, the Trustees shall apply Trust assets to reasonable and necessary expenses incurred in such termination, and payment of benefits hereunder until Trust assets are exhausted. All amendments, modifications and terminations shall be in writing and shall be approved by the Trust in accordance with its normal procedures for transacting business. Upon termination or discontinuance of the Plan, all elections and reductions in Salary or Wages relating to the Plan shall terminate, and reimbursements shall be made as if all Employees had terminated employment.

10.2 Governing Law. The Plan shall be construed, administered and enforced in accordance with Washington law, Code Section 125 and regulations thereunder, and, to the extent applicable, ERISA.

10.3 Limitation of Rights. Neither the establishment of the Plan nor any amendment thereof will be construed as giving to any Employee or other person any legal or equitable right against the Plan Administrator, the Trust or the Employers, except as expressly provided herein, and in no event will the terms of employment or service of any Employee be modified or in any way be affected hereby. Without limiting the foregoing, nothing in the Plan shall be construed as

a contract of employment or as consideration or inducement for employment, or a limitation of an Employer's rights to terminate any Employee with or without cause.

10.4 Funding Benefits Solely from General Assets. The Plan shall be funded with amounts withheld from Salary or Wages, as allocated pursuant to Election Forms from Participants, and by Employer contributions for premiums and the payment of administration expenses. The benefits provided hereunder to a Participant will be paid solely from the assets of the Trust and from insurance. Nothing herein will be construed to require the Employer to maintain any other fund or segregate any other amount for the benefit of any Participant, and no Participant or other person shall have any claim against, right to, or security or other interest in, any fund, account or asset of the Plan Administrator, Employer or the Trust from which any payment under the Plan may be made. Each Employer's accounts shall be separately administered.

10.5 Nonassignability of Rights. The right of any Participant to receive any payment or reimbursement under the Plan shall not be transferred by the Participant by assignment or any other method, and shall not be subject to attachment by creditors by any process whatsoever, and any attempt to cause such right to be so transferred or attached will not be recognized; provided, however, that payment for benefits with respect to a Participant under the Health Care Reimbursement Plan or the Limited Health Care Reimbursement Plan will be made in accordance with any assignment of rights made by or on behalf of such Participant as a beneficiary of such Participant as required by a state plan for medical assistance approved under Title XIX of the Social Security Act pursuant to Section 1912(a)(1)(A) of such Act (as in effect on the date of the enactment of the Omnibus Budget Reconciliation Act of 1993).

10.6 No Guarantee of Tax Consequences. The Employers, the Plan Administrator, and the Trust make no commitment or guarantee that any amounts paid to or for the benefit of a Participant under any provision of this Plan will be excludable from the Participant's gross income for federal or state income tax purposes, or that any other federal or state tax treatment will apply to or be available to any Participant. It shall be the obligation of each Participant to determine whether each payment under this Plan is excludable from the Participant's gross income for federal and state income tax purposes, and to notify the Plan Administrator if the Participant has reason to believe that any such payment is not so excludable, and absent any such notice, all such payments shall be reported as nontaxable.

10.7 Indemnification of Employer by Participant. If any Participant receives one or more payments or reimbursements under Section 5.2 or Section 7.2 of this Plan that are not for Medical Expenses, or under Section 6.2 of this Plan that are not for Dependent Care Expenses, such Participant shall indemnify and reimburse the Trust and/or the Employers for any liability they may incur for failure to withhold federal income tax or Social Security tax from such payments or reimbursements.

10.8 No Deferred Compensation. In no event shall benefits under the Plan be provided in the form of deferred compensation.

10.9 Health Care Reimbursement Plan Provisions.

a. Mental Health Parity. Benefits under the Health Care Reimbursement Plan or, to the extent applicable under the Limited Health Care Reimbursement Plan, shall be provided in compliance with the Mental Health Parity Act of 1996. Any aggregate lifetime limit on such benefits shall apply both to medical and surgical benefits and to mental health benefits.

b. Maternity Benefits. Under federal law, group health plans and health insurance issuers offering group health insurance generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or the newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, the plan or issuer may pay for a shorter stay if the attending physician (e.g., your physician, nurse, or midwife, or a physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under federal law, plans and insurers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a plan or issuer may not, under federal law, require that a physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain precertification. For information on precertification, contact your Plan Administrator.

c. Medicaid. Benefits under the Health Care Reimbursement Plan and the Limited Health Care Reimbursement Plan shall be provided in compliance with Section 609(b) of ERISA.

d. USERRA. Benefits under the Health Care Reimbursement Plan and the Limited Health Care Reimbursement Plan shall be provided in compliance with the provisions of USERRA applicable to health plans.

e. Qualified Medical Child Support Order. A "Qualified Medical Child Support Order" is a Medical Child Support Order which creates or recognizes the existence of an

Alternate Recipient's right to, or assigns to an Alternate Recipient the right to, receive benefits for which a Participant or beneficiary is eligible under the Health Care Reimbursement Plan or the Limited Health Care Reimbursement Plan, and which clearly specifies the following:

(1) The name and last known mailing address of the Participant and the name and mailing address of each Alternate Recipient covered by the Order, except that, to the extent provided in the Order, the name and mailing address of an official of a state or political subdivision thereof may be substituted for the mailing address of any such Alternate Recipient.

(2) A reasonable description of the type of coverage to be provided to each Alternate Recipient, or the manner in which such type of coverage is to be determined.

(3) The period to which the Order applies.

An "Alternate Recipient" is any child of a Participant who is recognized under the Medical Child Support Order as having a right to enrollment under the Health Care Reimbursement Plan or the Limited Health Care Reimbursement Plan with respect to the Participant.

Notwithstanding any other Health Care Reimbursement Plan or other Limited Health Care Reimbursement Plan provision, the following procedures shall apply when any Medical Child Support Order is received by the Health Care Reimbursement Plan or the Limited Health Care Reimbursement Plan with respect to a Participant.

The Plan Administrator shall promptly notify the Participant, and each Alternate Recipient of the receipt of such Order and the Plan's procedures for determining whether Medical Child Support Orders are Qualified Medical Child Support Orders. The Plan Administrator shall permit each Alternate Recipient to designate a representative for receipt of

copies of notices that are sent to the Alternate Recipient with respect to a Medical Child Support Order.

(4) The Plan Administrator shall promptly after receipt of the Order determine whether the Order is a Qualified Medical Child Support Order, as defined in Section 609(a)(2)(A) of ERISA. The Plan Administrator shall promptly notify the Participant and each Alternate Recipient of its decision.

(5) An Alternate Recipient under a Qualified Medical Child Support Order shall be considered a beneficiary under the Plan.

(6) Any payment for benefits made by the Health Care Reimbursement Plan or the Limited Health Care Reimbursement Plan pursuant to a Medical Child Support Order in reimbursement for expenses paid by an Alternate Recipient or an Alternate Recipient's custodial parent or legal guardian shall be made to the Alternate Recipient or the Alternate Recipient's custodial parent or legal guardian.

f. COBRA. Benefits under the Health Care Reimbursement Plan or, to the extent applicable under the Limited Health Care Reimbursement Plan, shall be provided in accordance with COBRA and its regulations. A Participant and each Qualified Beneficiary who loses coverage under the Health Care Reimbursement Plan or, to the extent applicable under the Limited Health Care Reimbursement Plan, as a result of a qualifying event under COBRA shall be entitled to elect continuation coverage under the Health Care Reimbursement Plan or, to the extent applicable under the Limited Health Care Reimbursement Plan, for the Plan Year in which the Qualifying Beneficiary's qualifying event occurs. Any unused amounts will be forfeited at the end of the Plan Year and COBRA coverage will not be extended beyond the end of the Plan Year.

g. HIPAA Privacy and Security. The Health Care Reimbursement Plan and the Limited Health Care Reimbursement Plan are subject to the HIPAA privacy and security rules. The provisions of the HEWT HIPAA Privacy and Security Amendment are incorporated herein by reference.

10.10 Claims Procedures. Claims and reimbursement under the Plan shall be administered in accordance with the respective claims procedures applicable to the particular benefit, and set forth in the summary plan description, if any, for the benefit.

10.11 Severability; Construction. If any provision of the Plan is declared invalid or unenforceable, such provision will not affect the remainder of the Plan which shall be construed as if such provision had not been inserted. Whenever used in this Plan, the masculine gender shall include other genders as well, and singular usage shall include plural usage, as the context may require. Headings and numbers in the Plan are included for convenience reference only.

10.12 Employer's Protective Clauses.

a. Upon the failure of either the Participant or the Plan Administrator to obtain the insurance contemplated by this Plan (whether as a result of negligence, gross neglect or otherwise), the Participant's Benefits shall be limited to the insurance premium(s), if any, that remained unpaid for the period in question and the actual insurance proceeds, if any, received by the Plan Administrator or the Participant as a result of the Participant's claim.

b. The Plan Administrator's liability to the Participant shall only extend to and shall be limited to any payment actually received by the Plan Administrator from the Insurer. In the event that the full insurance Benefit contemplated is not promptly received by the Plan Administrator within a reasonable time after submission of a claim, then the Plan Administrator shall notify the Participant of such facts and the Plan Administrator shall no longer have any

legal obligation whatsoever (except to execute any document called for by a settlement reached by the Participant). The Participant shall be free to settle, compromise or refuse to pursue the claim as the Participant, in his sole discretion, shall see fit.

c. The Plan Administrator shall not be responsible for the validity of any Insurance Contract issued hereunder or for the failure on the part of the Insurer to make payments provided for under any Insurance Contract. Once insurance is applied for or obtained, the Plan Administrator shall not be liable for any loss which may result from the failure to pay Premiums to the extent Premium notices are not received by the Plan Administrator.

10.13 Family and Medical Leave Act Of 1993 ("FMLA"). Notwithstanding anything in the Plan to the contrary, in the event any benefit under this Plan becomes subject to the requirements of the FMLA and regulations thereunder, this Plan shall be operated in accordance with Treas. Reg. Section 1-125-3. Without limiting the foregoing, if a Participant goes on a qualifying unpaid leave under FMLA, to the extent required by the FMLA, the Plan Administrator will continue to maintain the Participant's Health Insurance Benefits and Health Care Reimbursement Plan or, to the extent applicable the Participant's Limited Health Care Reimbursement Plan, on the same terms and conditions as though such Participant were an active Employee. If the Participant opts to continue coverage, the Participant may (a) pay his or her share of the premium for Health Insurance Benefits and his or her share of the contributions to the Health Care Reimbursement Plan or, to the extent applicable to the Limited Health Care Reimbursement Plan, with after-tax dollars while on leave (or pre-tax dollars to the extent he or she receives Compensation during the leave), or (b) the Participant may be given the option to pre-pay all or a portion of his or her share of the premium or contribution for the expected duration of the leave on a pre-tax salary reduction basis out of pre-leave compensation by

making a special election to the effect prior to the date such Compensation would normally be available (provided, however, that pre-tax dollars may not be utilized to fund coverage during the next Plan Year), or (c) via other arrangements agreed upon between the Participant and the Administrator (e.g., the Administrator may fund coverage during the leave and withhold amounts upon the Participant's return). Upon return from such leave, the Participant will be permitted to re-enter the Plan on the same basis the Participant was participating in the Plan prior to leave, or as otherwise required by the FMLA.

10.14 Forfeitures. Forfeitures under this Plan shall be applied to the payment of administrative expenses.

Executed this _____ day of _____, 2022.

HANFORD EMPLOYEE WELFARE TRUST

By _____
Its Chair

SCHEDULE A
ELIGIBLE EMPLOYERS

EMPLOYER	EIN	ADDRESS	ELIGIBLE PARTICIPANTS
CH2M Hill Plateau Remediation Company – Closeout Office	77-0694488	P.O. Box 1600, H8-17 Richland, WA 99352	Salaried
Central Plateau Cleanup Company LLC	83-1693373	P.O. Box 1464 Richland, WA 99352	Salaried and HAMTC
Washington River Protection *Solutions*, LLC	26-0771181	1200 Jadwin Avenue Richland, WA 99352	Salaried and HAMTC
Hanford Mission Integration Solutions, LLC	83-0947948	P.O. Box 943, H2-23 Richland, WA 99352	Salaried, HAMTC and HGU
Mission Support Alliance, LLC – Closeout Office	30-0419594	P.O. Box 650, H2-23 Richland, WA 99352	Salaried
North Wind Solutions, LLC	80-0651341	507 Knight St., Suite A Richland, WA 99352	Salaried and HAMTC
Advanced Technologies & Laboratories International, Inc. (operating together with Navarro Research & Engineering, Inc. as Hanford Laboratory Management and Integration, LLC)	51-0323647	555 Quince Orchard Road, Suite 500 Gaithersburg, MD 20878	Salaried and HAMTC
Navarro Research & Engineering, Inc. (operating together with Advanced Technologies & Laboratories International, Inc. as Hanford Laboratory Management and Integration, LLC)	62-1553678	1020 Commerce Park Drive Oak Ridge, TN 37830	Salaried and HAMTC